

Billing and Policy General Medicine Bulletin 347

June 2003

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Replacement Pages may be found in
the "Program and Eligibility" bulletin.
Articles with related Part 2 Manual
Replacement Pages may be found in
the "Billing and Policy" bulletin. The
Medi-Cal Update may not always
contain a "Billing and Policy" section.*



HIPAA Provider Training: Coming Soon

The Medi-Cal Training Seminar series will soon feature classes related to the Health Insurance Portability and Accountability Act (HIPAA). HIPAA classes will begin June 23, 2003 at the Medi-Cal Training Seminar in San Diego. HIPAA classes will help providers

increase knowledge and awareness of HIPAA regulations, standards and how current Medi-Cal billing practices will be affected.

Topics covered in the HIPAA training sessions include the following:

- An overview of how HIPAA regulations affect provider billing
- The history of HIPAA, from federal regulations to billing changes
- Upcoming changes to Medi-Cal related to HIPAA, including dates and time frames

For locations, dates, times and other seminar topics, please refer to the Medi-Cal Training Seminar flyer included with this *Medi-Cal Update* or the Medi-Cal Provider Relations Organization Web site at pro.medi-cal.ca.gov. To attend a HIPAA class, please call the Provider Support Center at 1-800-541-5555 (option "4") to register for a morning or afternoon training session. Look for more information in future *Medi-Cal Updates*.



HIPAA Implementation: Immunization Service Codes Conversion

Effective with the September 22, 2003 implementation of the Health Insurance

Portability and Accountability Act (HIPAA), the Department of Health Services (DHS) is implementing the use of *Current Procedural Terminology – 4th Edition* (CPT-4) codes when billing for immunizations. Healthcare Common Procedure Coding System (HCPCS) Level III local codes will no longer be reimbursable by Medi-Cal for dates of service on or after the HIPAA implementation date. Some of the policy changes are highlighted below.

Please see Implementation, page 2

Implementation *(continued)***Deleted HCPCS Codes**

The following HCPCS Level III local immunization codes will be deleted effective with the implementation of HIPAA.

X5300	X5332	X6232	X6842	X7106	X7914
X5302	X5334	X6234	X6844	X7438	X7916
X5304	X5336	X6268	X6950	X7439	X7918
X5306	X5338	X6270	X6954	X7440	X7920
X5308	X5340	X6272	X6956	X7441	X7922
X5310	X5342	X6276	X6960	X7472	X7924
X5312	X5344	X6279	X6990	X7474	X7926
X5314	X5346	X6281	X7024	X7476	X7930
X5316	X5676	X6314	X7088	X7900	X7932
X5318	X5730	X6350	X7090	X7902	X7934
X5320	X5938	X6538	X7092	X7904	X7936
X5321	X6098	X6542	X7094	X7906	X7938
X5322	X6100	X6768	X7096	X7908	X7940
X5324	X6102	X6772	X7098	X7910	X7942
X5326	X6218	X6774	X7100	X7912	
X5330	X6230	X6840	X7102	X7913	

Note: All HCPCS codes listed above remain payable only with a date of service prior to the September 22, 2003 implementation date.

CPT-4 Codes

Immunization services rendered on or after September 22, 2003 must be billed using the appropriate CPT-4 code from the following list:

90281	90585	90658	90701	90717	90743
90283	90586	90659	90702	90718	90744
90371	90632	90665	90703	90719	90746
90378	90633	90669	90704	90720	90747
90379	90634	90675	90705	90721	90748
90384	90636	90676	90706	90723	90749
90385	90645	90690	90707	90725	
90386	90646	90691	90708	90727	
90389	90647	90692	90712	90732	
90399	90648	90693	90713	90733	
90471	90657	90700	90716	90740	

Vaccines For Children (VFC) Program

Vaccine For Children (VFC) Program providers are required to use CPT-4 codes and the -SL modifier. The -SK modifier must also be used with VFC vaccine codes when appropriate.

Please see Implementation, page 3

Implementation *(continued)***CPT-4 Codes with Modifier -SL (State-Supplied Vaccine)**

Providers must use a VFC-provided vaccine when available and use modifier -SL with the CPT-4 code to bill for these immunizations. VFC providers who bill modifier -SL with the CPT-4 codes will be reimbursed only the Medi-Cal VFC program administration fee. The following codes must be billed with an -SL modifier for recipients 18 years of age and younger when using VFC-provided vaccines:

90632	90646	90659	90703	90713	90723
90633	90647	90669	90705	90716	90743
90634	90648	90700	90706	90718	90744
90636	90657	90701	90707	90720	90746
90645	90658	90702	90712	90721	90748

Note: Medi-Cal providers who are not VFC providers cannot use modifier -SL, since this service is available only for VFC providers.

CPT-4 Codes with Modifier -SK (High Risk)

Providers are required to bill modifier -SK with the CPT-4 codes listed below if the recipient is at high risk for the disease or condition for which the immune globulin/vaccine/toxoid is given. Providers are required to document in the recipient's medical record the medical reason why the recipient is "high risk" for the disease or condition for which the injection was administered. Providers are no longer required to submit the reason for high risk on the claim, but must do so on the medical record. The medical justification must meet Medi-Cal program policy for the immunization billed.

90632	90657	90675	90692	90725
90633	90658	90676	90693	90727
90634	90659	90690	90704	90732
90636	90665	90691	90717	90733

CPT-4 Codes with Modifier -SL and -SK

The following CPT-4 codes require both the -SL and -SK modifiers. These codes must be billed with both modifiers unless the VFC vaccine is not available.

90632	90634	90657	90659
90633	90636	90658	

Vaccine Availability

Providers unable to obtain VFC program vaccines in time to immunize VFC eligible recipients can bill the appropriate CPT-4 code for recipients younger than 19 years of age without the -SL modifier. Providers who bill any of the table listed codes for recipients younger than 19 years of age without modifier -SL are required to document justification why VFC vaccine was not used in the *Reserved For Local Use* field (Box 19) area of the claim or on a separate attachment. A provider's non-enrollment in the VFC program is not considered justification and such claims will be denied.

Please see Implementation, page 4

Implementation *(continued)*

VFC providers who bill the CPT-4 code but do not use the modifier -SL when required must document all of the following:

- The recipient is 18 years of age or younger,
- The provider has not used modifier -SL, and
- At least one of the following justifications is on the claim: a vaccine shortage, disease epidemic, VFC vaccine delivery problems or the recipient does not meet special circumstances required by the VFC program for the vaccine being billed.

Claims without such documentation will be denied and/or subject to audit.

Note: Providers are reminded that use of any vaccine or immunization solely for the purpose of travel or requirement of employment is not a Medi-Cal benefit.

Documentation for CPT-4 Codes 90399, 90749 and 90471

Effective for dates of service on or after the September 22, 2003 HIPAA implementation, reimbursement for CPT-4 code 90399 (unlisted immune globulin) and 90749 (unlisted vaccine/toxoid) require the name of the vaccine used, an invoice of the actual cost of the vaccine as well as medical justification in the *Reserved For Local Use* field (Box 19) area of the claim. Claims without such documentation will be denied. These codes may only be used when no CPT-4 code currently exists that could otherwise be used to bill for the immunization.

Claims billed for CPT-4 code 90471 (Immunization administration; one vaccine) require the name of the vaccine and medical justification in the *Reserved For Local Use* field (Box 19) area of the claim. Claims without such documentation will be denied. Providers cannot claim reimbursement for CPT-4 code 90471 for any vaccine that has an existing CPT-4 code since the Medi-Cal program already includes the administration fee in the reimbursement for the other CPT-4 immunization code billed.

Note: Code 90471 is billable only for administration of non-VFC vaccines that are furnished free of charge to the provider. CPT-4 code 90741 must not be billed for free vaccine supplied by the VFC program. Providers may not bill CPT-4 code 90741 for an additional administration fee when billing any other immunization code for the same immunization. CPT-4 code 90741 pays the usual non-VFC Medi-Cal program injection fee.

Documentation for CPT-4 Codes 90675 and 90676

Effective for dates of service on or after the September 22, 2003 HIPAA implementation, reimbursement for CPT-4 codes 90675 and 90676 (rabies vaccine) requires an invoice indicating the cost of the vaccine.

CPT-4 Code Unit Values

Some CPT codes are assigned specific unit values for Medi-Cal reimbursement purposes. Providers should note the unit values for the following CPT-4 codes that become effective on September 22, 2003:

<u>CPT-4 Code</u>	<u>Unit Value</u>	<u>CPT-4 Code</u>	<u>Unit Value</u>
90281	1 ml	90740	40 mcg
90283	1 gram	90743	10 mcg
90371	1 ml	90744	10 mcg
90378	50 mg	90746	10 mcg
90379	250 mg	90747	40 mcg
90386	600 units		

Manual pages reflecting these changes will be released in a future Medi-Cal Update.

New CHDP Manual: June Mailing

New Child Health and Disability Prevention (CHDP) Program provider manuals are being released this month for use beginning July 1, 2003. The CHDP Provider Manual and PM 160 Instructions Manual have been consolidated in the new manual, which also includes information about the new CHDP Gateway enrollment process.

Manual Assembly and Introduction Information

Currently enrolled CHDP providers will receive a manual package that contains:

- Assembly instructions
- Cover/spine
- Tabs
- Internet step-by-step user guide

Current POS device users will receive a new *POS Device User Guide* section in a separate mailing with information about Gateway POS device transactions. The current provider manual is effective through June 2003, except for the *Claims Processing* and *Provider Responsibilities: Laboratories* sections, as indicated in the new CHDP provider manual. The new manual will be effective July 1, 2003. To prepare for the July 1, 2003 start-up, manual users should follow the assembly instructions included in the manual package. Providers should also read the following introductory sections:

- A) *Manual Organization* – One-page overview
- B) *How to Use This Manual* – Details about manual components
- C) *Manual Ordering* – Ordering information

These sections provide an overview for navigating through the new alphabetically arranged CHDP provider manual.

CHDP Manual on the Internet

Internet users may access the new CHDP manual on the Medi-Cal Web site at www.medi-cal.ca.gov beginning July 1, 2003.

Provider Support

CHDP providers who do not receive their new manual packages by July 1, 2003, or who need assistance, may call the Provider Support Center (PSC) at 1-800-541-5555. Providers who are interested in becoming CHDP providers can contact their local CHDP program. (Please see www.dhs.ca.gov/chdp for a list of local CHDP programs.) Look for more information about the CHDP Gateway and Summer 2003 training classes in future *Medi-Cal Updates*.

Misuse of Benefits Identification Card: New BICs Issued

The Department of Health Services (DHS) Medical Review Branch is continuing to issue replacement Medi-Cal Benefits Identification Cards (BICs) in an ongoing effort to nullify BICs that may have been stolen or misused.

When providers attempt to verify eligibility for the recipients who receive new cards, the BIC ID number and issue date from the replacement card should be used. When the replacement card numbers are entered, eligibility information will be returned with the message, "For claims payment, current BIC ID numbers and date of issue required."

Please see BICs, page 6

BICs (*continued*)

If providers do not enter the most current issue date (from the replacement card), they may receive the message, “Issue date of the beneficiary’s ID card invalid.” The eligibility transaction may be allowed to continue. If this occurs, the provider would receive eligibility information and then the message, “For claims payment, current BIC ID number and date of issue required.” The ID number and issue date from the replacement card must be entered on all claims for these recipients. Refer to the March 2003 *Medi-Cal Update* for instructions on where to place the card issue date on claims.

The following providers are excluded from the claims payment requirement: Emergency Air Ambulance Transportation, Alternative Birthing Centers, Community Hospital Inpatient, Community Hospital Outpatient, County Hospital Inpatient, County Hospital Outpatient, Genetic Disease Testing, Emergency Ground Transportation, Certified Hospice, Long Term Care Facility and Mental Health Inpatient.

When referring recipients to other providers, such as laboratories, please indicate the BIC ID number and date of issue on the referral. If a provider, such as a laboratory, receives a referral without a recipient’s BIC ID number and issue date, the laboratory must contact the referring provider for this information. For assistance with eligibility, Automated Eligibility Verification System (AEVS), the Point of Service (POS) device or the Medi-Cal Web site, call the POS/Internet Help Desk at 1-800-427-1295. If illegal use of a BIC is suspected, or if you have questions about this policy, call the Provider Support Center (PSC) at 1-800-541-5555. Manual pages reflecting this information will be released in a future *Medi-Cal Update*.

Cancer Detection Programs: Every Woman Counts: 2003 Poverty Level Income Guidelines

The 2003 federal poverty level income guidelines are effective April 1, 2003 through March 31, 2004. The guidelines are used to determine financial eligibility for Cancer Detection Programs: Every Woman Counts. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following chart. For specific Cancer Detection Programs: Every Woman Counts questions, call the Health Access Programs (HAP) Hotline at 1-800-257-6900.

FEDERAL POVERTY INCOME GUIDELINES

200 Percent of Poverty by Family Size

Number Of Persons	Gross Monthly Income	Gross Annual Income
1	\$1,497	\$17,960
2	\$2,020	\$24,240
3	\$2,544	\$30,520
4	\$3,067	\$36,800
5	\$3,590	\$43,080
6	\$4,114	\$49,360
7	\$4,637	\$55,640
8	\$5,160	\$61,920
9	\$5,684	\$68,200
10	\$6,207	\$74,480
For each additional person, add	\$524	\$6,280

This information is reflected on manual replacement page can detect 7 (Part 2).

Presumptive Eligibility Program: 2003 Poverty Level Income Guidelines

The 2003 federal poverty income guidelines became effective April 1, 2003. The guidelines are used to determine applicant eligibility for the Presumptive Eligibility (PE) program. An applicant is eligible if her gross family income is at or below the revised poverty levels shown in the following chart. For specific Presumptive Eligibility questions, call the Health Access Programs (HAP) Hotline at 1-800-257-6900.

FEDERAL POVERTY INCOME GUIDELINES 200 Percent of Poverty by Family Size

Number Of Persons	Gross Monthly Income	Gross Annual Income
2	\$2,020	\$24,240
3	\$2,544	\$30,520
4	\$3,067	\$36,800
5	\$3,590	\$43,080
6	\$4,114	\$49,360
7	\$4,637	\$55,640
8	\$5,160	\$61,920
9	\$5,684	\$68,200
10	\$6,207	\$74,480
For each additional person, add	\$524	\$6,280

This information is reflected on manual replacement page presum 6 (Part 2).



Family PACT Program: 2003 Poverty Level Income Guidelines

The 2003 federal poverty level income guidelines are effective July 1, 2003. The guidelines are used to determine applicant eligibility for the Family PACT (Planning, Access, Care and Treatment) Program. Applicants are eligible if their gross family income is at or below the revised poverty levels shown in the following chart.

FEDERAL POVERTY INCOME GUIDELINES 200 Percent of Poverty by Family Size

Number Of Persons	Gross Monthly Income	Gross Annual Income
1	\$1,497	\$17,960
2	\$2,020	\$24,240
3	\$2,544	\$30,520
4	\$3,067	\$36,800
5	\$3,590	\$43,080
6	\$4,114	\$49,360
7	\$4,637	\$55,640
8	\$5,160	\$61,920
9	\$5,684	\$68,200
10	\$6,207	\$74,480
For each additional person, add	\$524	\$6,280

Please see Family PACT, page 8

Family PACT (continued)

Revised *Family PACT Policies, Procedures and Billing Instructions (PPBI)* pages will be issued in a future mailing to Family PACT providers. For more information regarding Family PACT, call the Health Access Programs (HAP) Hotline at 1-800-257-6900 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at www.familypact.org.

Somatropin (Serostim®): Revised Treatment Requirements

Effective June 1, 2003, growth hormone somatropin (Serostim®) is reimbursable only with an approved *Treatment Authorization Request (TAR)*.

Additionally, criteria for recipient body cell mass, body mass index and weight must be met and reassessed during the course of treatment with Serostim®.

The following is a review of criteria providers must follow in all stages of use of Somatropin therapy for the treatment of HIV-associated wasting.

Criteria for the initial 28 days of treatment of HIV-associated wasting with Serostim®:

- Documentation in the medical record of complete history and physical examination including:
 - History of nutritional status including appetite, estimation of caloric intake, gastrointestinal function including presence of diarrhea and number of daily stools, and history of endoscopic procedures.
 - Psychosocial evaluation, including presence of significant anxiety and/or depression affecting food intake.
 - Record of the following measurements:
 - Height, weight, ideal body weight, body mass index (BMI).
 - Body cell mass (BCM) by bioelectrical impedance analysis (BIA).
 - Serial measurements – weekly.
 - Recipients must meet one of the following criteria for HIV-associated wasting:
 - 5 percent BCM loss within the preceding six months.
 - In men: BCM less than 35 percent of total body weight and BMI less than 27 kg/m².
 - In women: BCM less than 23 percent of total body weight and BMI less than 27 kg/m².
 - BMI less than 20 kg/m².
 - BMI greater than 20 kg/m² and less than 25 kg/m²
- and
- ❖ 10 percent unintentional weight loss within the preceding 12 months.
- or
- ❖ 7.5 percent unintentional weight loss within the preceding six months.

Please see Somatropin, page 9

Somatropin *(continued)*

- Recipients should have an evaluation of gastrointestinal function with attention to the presence of malabsorption, a review of food intake, amount of daily calories and estimate of physical activity level.
- An active malignancy other than Kaposi's sarcoma has been excluded clinically, through diagnostic laboratory examination, and/or radiographically.
- Male recipients should have a serum testosterone level and, if low, a trial of testosterone replacement therapy.
- Recipients must have a viral load assay and a CD4 count and must be undergoing treatment with an appropriate antiretroviral therapy regimen.
- Recipients should have a trial with an appetite stimulant if the recipient has inadequate caloric intake and anorexia.
- For male recipients, an initial trial of androgen is recommended for HIV-associated wasting. If this is omitted, a statement should be provided documenting the clinical decision to proceed directly with Serostim[®] therapy.
- Recipients must receive Serostim[®] within recommended dosing guidelines for body weight.
- Documentation of CD4 counts less than 50 (within the last three months prior to treatment with Serostim[®]).

Criteria for reassessment of therapy through 12 weeks:

- Treatment must be re-evaluated after four weeks and eight weeks of therapy. Repeat weight assessment and documentation is required at four weeks and eight weeks of therapy to assure weight stabilization.
 - Therapy must be discontinued in recipients who continue to lose weight in the first four weeks of treatment.
 - If, after four weeks of therapy, weight loss has stopped or if the recipient is gaining weight, Serostim[®] may be continued for another 28 days.
 - If, after eight weeks of therapy, the recipient is losing or has failed to gain weight from the original measurement, Serostim[®] must be stopped.
 - If the recipient had initially gained weight at four weeks, but has neither gained nor lost weight at the eight-week re-evaluation, Serostim[®] may be continued for another 28 days.
 - A maximum of 12 weeks of treatment is allowed with prior authorization. Claims without prior authorization will be denied.
- Note:** Prior authorization is limited to four-week intervals.

Criteria for continued therapy beyond the initial 12 weeks:

All recipients must stop Serostim[®] following the initial 12-week treatment for an eight-week period of observation unless there is documentation that HIV-associated wasting is still present. During the eight-week observation period, body weight, BMI and BCM should be monitored on a weekly basis.

Please see Somatropin, page 10

Somatropin (*continued*)

- Therapy beyond 12 weeks may be continued with a recipient who has demonstrated a beneficial response to Serostim[®] during the initial 12 weeks of therapy (defined as a 2 percent or greater increase in body weight or BMI)

and

- Still exhibits evidence of wasting (BMI less than 20 kg/m²)
or
- Has a BCM not yet normalized (BCM less than 40 percent in non-obese men or less than 28 percent in non-obese women).
- As long as the recipient continues to gain weight or BCM, Serostim[®] may be extended every 28 days, with prior authorization, until BCM and/or weight are normalized.
- Once BCM and/or weight have normalized, Serostim[®] should be stopped.

Criteria for reinitiating Serostim[®] therapy within six months:

- Recipients may resume Serostim[®] therapy within six months of initial therapy if there is documentation of an unintentional 5 percent loss of body weight or BCM loss of greater than 5 percent or any of the criteria for HIV-associated wasting within six months after completion of an uninterrupted 12-week course of Serostim[®] therapy.
- Reinitiating Serostim[®] is allowed for up to an additional 12 weeks, with reassessments required at the same four and eight week intervals during the second 12-week course of therapy. A recent copy of the recipient's (BIA) documenting the BCM loss is required with TAR submission.

Criteria for repeat Serostim[®] therapy six months after cessation of treatment:

- If the recipient has not reinitiated Serostim[®] six months after completing an uninterrupted 12-week course of therapy, Serostim[®] may be repeated, provided the criteria for initial 28 days of therapy are met. Reinitiating Serostim[®] is allowed for up to an additional 12 weeks, with reassessments required at the same four and eight week intervals during the second 12-week course of therapy. A recent copy of the recipient's BIA is required with TAR submission.
- Trials of alternate treatment may be omitted if previous use in the recipient was unsuccessful. The use of Serostim[®] beyond the initial 12-week course must meet the criteria stated above for continued treatment.

This information is reflected on manual replacement pages inject 41 thru 44 (Part 2).

Obstetrical Anesthesia: Billing Reminder

Providers are reminded that CPT-4 codes 01960 – 01964, 01968 and 01969 may be billed for general, regional, or both general and regional anesthesia. Providers billing with any of these codes must include a statement in the *Reserved For Local Use* field (Box 19) of the claim documenting whether the anesthesia was general, regional or both. Claims without such documentation will be denied. Claims billed for general anesthesia with codes 01960 – 01964, 01968 and 01969 must document “start-stop” and total times in the *Reserved For Local Use* field (Box 19). Providers billing these codes for regional or both general and regional anesthesia must document “time in attendance” (in addition to the “start-stop” and total times, if general anesthesia was also administered) in the *Reserved For Local Use* field (Box 19). For more information, refer to the *Anesthesia* section in the appropriate Part 2 Medi-Cal provider manual.

Upper Billing Limit Regulation: Reminder

Effective March 1, 2003, claims submitted to Medi-Cal for Durable Medical Equipment (DME), medical supplies, incontinence medical supplies, and orthotic and prosthetic appliances identified with a single asterisk in the *California Code of Regulations* (CCR), Title 22, Section 51515, shall not exceed an amount that is the lesser of (1) the usual charges made to the general public or (2) the net purchase price of the item, which must be documented in the provider's books and records, plus no more than a 100 percent markup (CCR, Title 22, Section 51008.1).

Providers also are prohibited from submitting claims for DME, supplies and appliances that were obtained at no cost (CCR, Title 22, Section 51008.1).

This regulation does not alter Medi-Cal's statutory or regulatory maximum reimbursement rates.

This information is reflected on hcfa spec 6 (Part 2).

CPSP Manual Updates: Billing Examples

Medi-Cal updated select pages of the provider manuals to correctly reflect reimbursement rates for the Comprehensive Perinatal Services Program (CPSP). The new billing example rates reflect increases implemented for dates of services on or after August 1, 2000. *The updated information is reflected on manual replacement pages preg com 10 and 11 (Part 2) and preg com exh 2, 4 and 7 thru 9 (Part 2).*

Medi-Cal List of Contract Drugs: Updates

The following provider manual section has been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drug* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications*.

Additions, effective June 1, 2003

<u>Drug</u>	<u>Size and/or Strength</u>
* EZETIMIBE + Tablets	10 mg
* Restricted to treatment of patients currently on a lipid-lowering agent.	
LOVASTATIN + Tablets, extended release	40 mg 60 mg

*Please see **Contract Drugs**, page 12*

Contract Drugs *(continued)*

Changes, effective June 1, 2003

* INTERFERON ALFACON-1

Injection	30	mcg/cc	0.3 cc
		0.5 cc	

Injection, prefilled syringe	30	mcg/cc	0.3 cc
		0.5 cc	

* Restricted to use in the treatment of chronic hepatitis C virus infection.

(NDC labeler code 55513 [Amgen USA] only.)

LEVONORGESTREL AND ETHINYL ESTRADIOL

Tablets	0.1 mg– 20 mcg	Tablets from 21 tablet packet
		Tablets from 28 tablet packet

(NDC labeler code 00008 [Wyeth Laboratories] only.)

Instructions for Manual Replacement Pages

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Part 2

Remove and replace:

- anest hcfa 3/4
- can detect 7/8
- hcfa spec 5/6
- inject 41 thru 44
- mcp ffs bil 1/2 *
- preg com 9 thru 12
- preg com exh 1 thru 4, 7 thru 9
- presum 5/6
- tar and non cd9 1/2

* Pages updated/corrected due to ongoing provider manual revisions.